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	185408	A. BUILDING _____ B. WING _____	C 04/27/2012

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KINDRED NURSING AND REHABILITATION-LIBERTY	616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539

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F 000	INITIAL COMMENTS An abbreviated standard survey (KY18173) was initiated on 04/25/12 and completed on 04/27/12. The complaint was substantiated and deficiencies were cited at a scope and severity of "J" at 42 CFR 483.20 Resident Assessment (F282), and 42 CFR 483.25 Quality of Care (F323), with Substandard Quality of Care at 42 CFR 483.25 Quality of Care. The facility failed to have an effective system to ensure adequate supervision and assistive devices were provided to prevent accidents for one of eight sampled residents (Resident #1). Resident #1 was assessed by the facility to be at risk for elopement. The resident was assessed to require a wander alert bracelet and increased supervision when exit seeking behaviors were displayed. However, the facility failed to ensure Resident #1 was provided the interventions, and on 04/01/12, the resident eloped from the facility without staff knowledge and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at 2:45 PM, and found outside at approximately 3:25 PM (thirty-five minutes later), by a staff member who was outside on a scheduled break. Resident #1 was assisted back inside the facility and assessed to have sustained no injuries. The Immediate Jeopardy was identified on 04/27/12, and determined to exist on 03/06/12 and continue through 04/09/12. The Immediate Jeopardy was removed on 04/10/12. The facility completed corrective actions prior to the State Agency's investigation on 04/25/12; therefore, the Jeopardy was determined to be Past Jeopardy.	F 000		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 282	Continued From page 1 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined the facility failed to have an effective system to ensure services were provided in accordance with each written comprehensive plan of care for one of eight sampled residents (Resident #1). The facility identified Resident #1 to be at risk for elopement and developed a care plan with interventions including a wander alert bracelet and providing the resident with increased supervision when exit seeking behaviors were displayed, in an effort to reduce the likelihood of the resident leaving safe areas in the facility. However, the facility failed to ensure the interventions were implemented as detailed in the resident's plan of care. On 04/01/12, Resident #1 exited the building without staff knowledge, and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at 2:45 PM, and found outside at approximately 3:25 PM (thirty-five minutes later). Resident #1 was escorted back inside the building and assessed to have sustained no injuries. The facility's failure to have an effective system in place to ensure services were provided in accordance with each individual's written plan of	F 282	Past noncompliance: no plan of correction required.	

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care was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 03/06/12, and continued until 04/10/12. The facility completed corrective actions prior to the State Agency's investigation on 04/25/12; therefore, the Jeopardy was determined to be Past Jeopardy.

The findings include:

A review of the facility's Accidents and Supervision to Prevent Accidents, Elopement Risk Evaluation (both revised on 04/28/11) revealed the facility would identify residents at risk for elopement and implement measures to reduce the likelihood of the resident successfully eloping from the facility.

A review of the facility's Comprehensive Plan of Care policy/procedure (revised 05/28/08) revealed any "new or changed" care plans would be communicated to members of the IDT and caregivers for implementation. The entity responsible for the development of the "new or changed" care plan was also responsible to ensure any cues were placed appropriately to remind caregivers of the resident's special needs.

A review of a facility investigation revealed Resident #1 successfully eloped from the facility on 04/01/12, without staff knowledge, and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at 2:45 PM, and was found outside the facility at approximately 3:25 PM. The facility investigation concluded Resident #1 most likely exited the facility via the front entrance as a visitor was entering/leaving the building. The facility's

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investigation and interview with the Administrator on 04/25/12, at 5:30 PM, revealed all exit doors in the facility including the front door were equipped with the wander alert system, which would have sounded if Resident #1 had been wearing a wander alert bracelet.

A review of Resident #1's admission assessment conducted on 02/21/12, revealed the facility admitted the resident with diagnoses including Frontal Craniotomy Colloid Cyst Resection, Seizure Disorder, Dementia, and Blindness in the Left Eye. Resident #1 was not assessed by the facility to be at risk for elopement at that time.

A review of a wander/elopement assessment dated 02/28/12, revealed Resident #1 had been identified to be at risk for elopement due to displaying exit seeking behaviors. A review of Resident #1's Care Plan revealed the facility added an "update" to the resident's plan of care on 02/28/12, due to having been assessed as an elopement risk. A physician's order was obtained on 02/28/12, and a wander alert bracelet was implemented and placed on Resident #1. The wander alert bracelet intervention was to be reassessed at "the next review." Review of Resident #1's medical record revealed the resident was transferred to a Behavioral Health Unit on 02/29/12, due to the resident's escalating behaviors of increased aggression and attempting to exit the facility.

Resident #1 no longer resided at the facility at the time of the investigation, therefore a closed record review was conducted. According to Resident #1's medical record, the resident was readmitted to the facility on 03/06/12. An

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F 282	Continued From page 4 interview with Licensed Practical Nurse (LPN) #4 on 04/27/12, at 2:10 PM, revealed she completed a wander/elopement assessment for Resident #1, as required, after being readmitted to the facility. However, LPN #4 stated the assessment was based only on Resident #1's behaviors at that exact time, and due to the resident voicing no desire to leave the facility, LPN #4 determined the resident was not at risk for elopement. LPN #4 stated, "It never entered my mind" to place a wander alert bracelet on Resident #1. LPN #4 stated she was unaware the resident had been assessed to require the bracelet or had received a physician's order on 02/28/12, for the bracelet prior to being transferred to the Behavioral Health Unit on 02/29/12. Interviews conducted with the Social Services Director on 04/25/12, at 5:00 PM; on 04/26/12, at 10:45 AM, 11:50 AM, and 4:30 PM; and on 04/27/12, at 1:25 PM, revealed that although Resident #1's readmission to the facility was discussed by the Interdisciplinary Team (IDT) on 03/07/12, the IDT failed to recognize the inaccuracy of the wander/elopement assessment completed by LPN #4 on 03/06/12, failed to ensure staff was aware that Resident #1 had been assessed as being an elopement risk on 02/28/12, and failed to ensure the resident was provided a wander alert bracelet as specified on the resident's plan of care. Further review of Resident #1's Comprehensive Plan of Care and continued interview with the SSD revealed Resident #1's care plan was again revised on 03/09/12, by the SSD to incorporate the elopement "update" from 02/28/12, into the resident's "formal" care plan, which included not	F 282		

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only the original intervention of the wander alert bracelet, but additional standard and/or resident specific interventions initiated by the facility for residents determined to be at risk for elopement. Interventions initiated for Resident #1, in addition to the wander alert bracelet, included providing the resident with increased supervision when exit seeking behaviors were displayed. However, the SSD stated in the interviews that no action was taken by the facility to alert any staff member to the revisions made to Resident #1's care plan on 02/28/12, or 03/09/12, related to the resident being at risk for elopement from the facility.

According to Resident #1's Minimum Data Set (MDS) assessment dated 03/14/12, the facility identified Resident #1 to be moderately cognitively impaired and have physical, verbal, and other behavioral symptoms. The facility further determined Resident #1's behaviors placed the resident at significant risk for physical illness or injury and significantly interfered with the resident's care.

Review of Resident #1's progress notes dated 03/17/12, revealed the resident again displayed exit seeking behaviors and voiced to staff that he/she was leaving the facility. However, interview with LPN #1 on 04/26/12, at 11:00 AM, who documented the exit seeking behaviors displayed by Resident #1 on 03/17/12, revealed no increased supervision was provided for the resident. LPN #1 stated she was unaware that the facility had determined Resident #1 was an elopement risk, and had no knowledge that interventions were in place and should be utilized when the resident displayed exit seeking behaviors. LPN #1 stated Resident #1

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ambulated at will throughout the facility, and had never been considered an elopement risk or worn a wander alert bracelet prior to 04/01/12.

Interviews conducted on 04/25/12, at 12:03 PM with LPN #2, at 3:45 PM with Certified Nursing Assistant (CAN) #1; on 04/26/12, at 11:20 AM with Registered Nurse (RN) #1; and on 04/27/12, at 11:58 AM with CNA #4, 12:05 PM with CNA #3, 12:10 PM with RN #2, 12:15 PM with CNA #2, and 12:20 PM with LPN #3, revealed the facility had never made them aware that Resident #1 was considered at risk for elopement, and had never seen Resident #1 wear a wander alert bracelet prior to 04/01/12. The staff stated Resident #1 voiced desires at times to go "outside" the facility and smoke but was reeducated on the smoking policy of the facility, which at times angered the resident. However, the staff stated Resident #1 ambulated freely in the facility, and was never provided an increased level of supervision to their knowledge.

*The facility implemented the following actions to correct the deficiency:

Resident #1 was returned to his/her unit and assessed to have sustained no injury. The resident was immediately placed on 1:1 monitoring, which continued until Resident #1 was transferred to the hospital on 04/11/12. Resident #1's attending physician and responsible party were notified of the resident's elopement from the facility.

On 04/01/12, the Charge Nurse reviewed and revised Resident #1's wander/elopement Risk Evaluation to reflect the resident's risk for

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elopement. A wander alert bracelet was placed on the resident.

After Resident #1 returned to the unit on 04/01/12, the Weekend Supervisor conducted a resident head count and all other residents were accounted for.

On 04/01/12, the Director of Nursing (DON) reviewed all wander/elopement assessments and care plans for all residents previously identified at risk for elopement for accuracy; the assessments and care plans were deemed to be accurate.

An audit of wander/elopement assessments for readmission for the past three months (February-April 2012) was conducted by the Case Manager (CM) and Minimum Data Set (MDS) Coordinator on 04/03/12. Resident Care plans were also audited to ensure the information on the wander/elopement assessment was consistent and contained on the resident's plan of care. Four reassessments were taken to the Interdisciplinary Team meeting for review.

On 04/03/12, the Staff Development Coordinator (SDC) initiated education with all facility staff, to include all departments, on elopement/missing resident protocols, including the newly adopted procedure for dealing with residents who are newly identified as having wandering/exit seeking behaviors. The newly adopted procedure included:

When newly identified exit seeking behaviors are identified interventions will be determined based on the assessment findings.

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Residents will be reassessed for risk of wandering/elopement, with appropriate interventions incorporated into the resident's plan of care.

Any new or revised care plan interventions will be communicated to the nursing staff, who will be responsible to place the new/revised intervention for the resident on the 24-hour nursing report, inform the CNA caring for the resident at the time, and update the CNA assignment sheet with the new information.

The 24-hour report and CNA sheet will then be reviewed the next morning by the IDT to ensure the new interventions have been effectively communicated to staff.

Education continued through 04/09/12. Staff was not allowed to work without having attended the in-service by 04/09/12.

An Elopement Audit was initiated on 04/02/12, and continues at least twice a week. Each resident identified at risk for elopement is audited to ensure that the wander/elopement assessment is up to date and accurate, the photo is on the assessment, the care plan is in place, the wander alert bracelet is in place on the resident, the resident's photo is in the book/binder, the resident's photo is on the adventure board, and the resident's care plan is being implemented. Care plan implementation will be validated through direct observation of the resident. The DON, SSD, or Weekend Supervisor is responsible to conduct the audit. Any concerns identified will be corrected at the time of the audit. The audit will be reviewed by the Interdisciplinary

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F 282	Continued From page 9 Team (IDT) the following day. On 04/02/12, the SSD placed binders at each nursing station and at the front desk containing pictures, assessments, and care plans of all residents identified at risk for elopement. The SSD audits the binders weekly and makes revisions if necessary. All audits will be tracked and trended and reviewed at the monthly Performance Improvement Committee (members include, but are not limited to the Administrator, DON, SSD, SDC, Maintenance Director, Medical Records Director, Registered Dietitian (RD), Activity Director, Nursing Services Manager, Minimum Data Set Coordinator, and Medical Director) for three months and as needed thereafter. **The surveyor validated the corrective action taken by the facility as follows: A review of Resident #1's medical record revealed the facility had assessed the resident and found no injuries. Documentation revealed the resident was placed on 1:1 monitoring until transfer to the hospital on 04/11/12, and documentation was present of physician/responsible party notification. Interviews with direct staff throughout the investigation revealed Resident #1 remained on 1:1 until transferred from the facility. Interview with LPN #1 on 04/26/12, at 11:00 AM, and review of the wander/elopement assessment for Resident #1 dated 04/01/12, revealed the form had been updated to reflect the resident's risk for elopement.	F 282		

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F 282	Continued From page 10 Interview with RN #1 on 04/26/12, at 11:20 AM, and facility documentation revealed she had completed a head count for the entire facility after Resident #1 was returned inside the building, and identified no concerns. Interview with the DON on 04/27/12, at 11:25 AM, and review of facility documentation confirmed the DON had performed the following actions: On 04/01/12, the Director of Nursing Services (DON) reviewed all wander/elopement assessments and care plans for all residents previously identified at risk for elopement for accuracy; the assessments were deemed to be accurate. Interview with the Case Manager (CM) and Minimum Data Set (MDS) Coordinator on 04/27/12, at 11:32 AM, and review of an audit dated 04/03/12, confirmed an audit of wander/elopement assessments and care plans for all readmissions in the past three months (February-April 2012) was conducted by the Case Manager (CM) and Minimum Data Set (MDS) Coordinator on 04/03/12. The wander/elopement assessments and care plans were compared to ensure accuracy and consistency. Interview with the SDC on 4/27/12, at 11:50 AM, and review of an Elopement Class Sign in sheet confirmed on 04/03/12, the Staff Development Coordinator (SDC) initiated education with all facility staff, to include all departments, on elopement/missing resident protocols, including procedures to ensure newly reviewed/revised care plan interventions are effectively communicated to staff. Education continued	F 282		

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through 04/09/12. Staff was not allowed to work without having attended the in-service by 04/09/12. Interviews conducted on 04/27/12, at 11:32 AM with the Case Manager and MDS Coordinator, at 11:58 AM with CNA #4, at 12:05 PM with CNA #3, at 12:10 PM with RN #2, at 12:15 PM with CNA #2, at 12:20 PM with LPN #3, at 1:00 PM with the Maintenance Director, and at 1:05 PM with the Central Supply Clerk revealed all the staff had attended the in-service, and was knowledgeable regarding the facility's elopement policies and procedures including procedures to ensure newly reviewed/revised care plan interventions are effectively communicated to staff.

Review of wander/elopement assessment audits dated 04/02/12, 04/03/12, 04/04/12, 04/05/12, 04/06/12, 04/07/12, 04/08/12, 04/13/12, 04/16/12, 04/19/12, and 04/24/12, confirmed Elopement Audits were initiated on 04/02/12, and have continued at least twice a week.

Observations on 04/27/12, at 1:18 PM, revealed "Adventure Club" binders were located at both nurses' stations and at the front desk. The binders contained resident pictures, assessments, and care plans of all residents identified at risk for elopement.

A review of a wander/elopement assessment Review confirmed all readmissions from 04/02/12-04/25/12, had been reassessed the day after readmission to the facility to ensure the wander/elopement assessments were accurate.

A review of Performance Improvement Committee (PIC) Minutes dated 04/03/12,

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F 282	Continued From page 12 confirmed the PIC met on 04/03/12, and reviewed the investigative findings, audits, and action plan created after the elopement of Resident #1 on 04/01/12. Review of wander/elopement assessment audits dated 04/02/12, 04/03/12, 04/04/12, 04/05/12, 04/06/12, 04/07/12, 04/08/12, 04/13/12, 04/16/12, 04/19/12, and 04/24/12, confirmed Elopement Audits were initiated on 04/02/12, and have continued at least twice a week. Observations on 04/27/12, at 1:18 PM, revealed "Adventure Club" binders were located at both nurses' stations and at the front desk. The binders contained resident pictures, assessments, and care plans of all residents identified at risk for elopement. A review of a wander/elopement assessment review confirmed all readmissions from 04/2/12-04/25/12, had been reassessed the day after readmission to the facility. A review of Performance Improvement Committee (PIC) Minutes dated 04/03/12, confirmed the PIC met on 04/03/12, and reviewed the investigative findings, audits, and action plan created after the elopement of Resident #1 on 04/01/12.	F 282		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, and policies and procedures, it was determined the facility failed to have an effective system to ensure that each resident received adequate supervision and assistive devices to prevent accidents for one of eight sampled residents (Resident #1). Although the facility had identified Resident #1 to be an elopement risk on 02/28/12, after displaying exit seeking behaviors, the facility failed to effectively reassess the resident's risk of elopement on 03/06/12, after the resident was readmitted to the facility following an admission to a Behavioral Health Unit. Resident #1 had been previously assessed to require a wander alert bracelet and increased supervision when exit seeking behaviors were displayed, but the facility did not provide the assistive device to Resident #1 after returning to the facility on 03/06/12, and also failed to ensure staff was aware that the resident was at risk for eloping from the facility. On 04/01/12, Resident #1 exited the facility without staff knowledge and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at 2:45 PM, and was discovered outside at approximately 3:25 PM, thirty-five minutes later. Resident #1 was escorted back into the facility by staff, and assessed to have sustained no injuries. The facility's failure to have an effective system in	F 323	Past noncompliance: no plan of correction required.	

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place to ensure adequate supervision and monitoring for residents who were at risk for elopement was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 03/06/12, and continued until 04/10/12. The facility completed corrective actions prior to the State Agency's investigation on 04/25/12; therefore, the Jeopardy was determined to be Past Jeopardy.

The findings include:

A review of the facility's Accidents and Supervision to Prevent Accidents, Elopement Risk Evaluation, and Risk Analysis policies/procedures (all revised on 04/28/11) revealed the facility would identify residents at risk for elopement by completing a wander/elopement assessment upon admission, quarterly, annually, or with a significant change. The facility would then alert staff to those residents identified to be at risk for elopement and implement measures to reduce the likelihood of the resident successfully eloping from the facility. The facility was to provide supervision to each resident to prevent avoidable accidents, and assess residents to determine what supervision was necessary.

A review of a facility investigation dated 04/06/12, revealed on 04/01/12, at approximately 3:20 PM, staff discovered Resident #1 outside the facility without staff supervision. According to the facility's investigation, the last time Resident #1 was seen inside the facility was at approximately 2:45 PM (35 minutes prior to being found outside). The facility investigation determined that Resident #1 had exited the front door of the

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facility most likely while a visitor was either entering or exiting the building. Resident #1 was found behind the building, 113 feet from the front door of the facility, by a staff member outside on a scheduled break.

Resident #1 no longer resided at the facility at the time of the investigation, therefore a closed record review was conducted. Observations on 04/25/12, revealed all facility doors which exit to the outside of the building on residential units required key pad entry to exit, and were equipped with the Wander Guard Alert System.

The facility admitted Resident #1 on 02/21/12, with diagnoses including Frontal Craniotomy Colloid Cyst Resection, Seizure Disorder, Dementia, and Blindness in the Left Eye. A review of the admission nursing assessment for Resident #1 revealed no exit seeking behaviors were identified.

Resident #1's Care Plan, Resident Progress Notes, and medical record review revealed on 02/28/12, the facility identified Resident #1 to have increased confusion and behavioral outbursts and the resident was attempting to leave the facility. A wander/elopement assessment was completed for Resident #1 which determined Resident #1 was at risk for elopement from the facility. The facility's Social Services Director (SSD) recorded in Resident #1's Progress Notes on 02/28/12, at 3:40 PM, that the resident was stating he/she "had a car outside and was going out to it to drive home." Additionally, the SSD documented Resident #1 had attempted to exit several facility doors, and staff was unable to redirect the resident from the

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behavior. Resident #1's physician was notified of the behaviors and a "wander alert bracelet" was placed on Resident #1. According to the medical record, on 02/29/12, Resident #1 was transferred to a Behavioral Health Unit for having displayed behaviors of attempting to physically harm staff, threatening staff and roommate, and attempting to leave the facility.

The facility readmitted Resident #1 from the Behavioral Health Unit on 03/06/12. An interview on 04/26/12, at 2:10 PM, with the nurse (LPN #4) who readmitted Resident #1 on 03/06/12, revealed she completed a wander/elopement assessment for Resident #1 and determined the resident was at risk for "wandering" but not at risk for elopement. The evaluation stated "resident wanders halls on South and North, and voices no desire to leave at this time." LPN #4 stated she had received no training on specifically completing the wander/elopement assessment and completed the assessment solely based on Resident #1's actions at the time of the assessment. LPN #4 stated she answered "no" to the questions "Does the resident express a desire to leave the center?" and "Does the resident express anger at being placed in a nursing home?" despite completing assessment due to the resident being readmitted to the facility from a Behavioral Health Unit after displaying aggressive behaviors toward staff and peers, and attempting to leave the facility. According to LPN #4, Resident #1 was very cooperative at that time and made no mention of leaving the facility. LPN #4 stated she had not utilized any previous behavioral history or considered any other factors which might place Resident #1 at risk for elopement when completing the assessment.

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LPN #4 went on to say that since she had determined Resident #1 was not at risk for elopement she did not attempt to obtain a physician's order for, or place a wander alert bracelet on, the resident, stating, "It never entered my mind."

Interviews with the SSD on 04/25/12, at 5:00 PM, on 04/26/12, at 10:45 AM, 11:50 AM, and 4:30 PM, and on 04/27/12, at 1:25 PM, revealed the Interdisciplinary Team (IDT) discussed Resident #1's readmission to the facility on 03/07/12, including the resident's wander/elopement assessment. However, the IDT failed to question the validity of the assessment or why Resident #1 was only at risk for wandering and not elopement, despite the resident having displayed behavioral outbursts and exit seeking behaviors seven days prior which had resulted in the resident's hospitalization. The SSD stated the IDT also failed to recognize, consider, or discuss the resident's continued need for a wander alert bracelet, but voiced that the resident "obviously should have had one" as previously determined.

A review of Resident #1's Care Plan revealed on 03/09/12, the resident's Care Plan problem for potential wandering and/or exit seeking behavior was updated to include additional standard and/or resident specific interventions initiated by the facility for residents determined to be at risk for elopement in addition to the wander alert bracelet intervention which the facility had assessed the resident to need and implemented on 02/28/12. The additional interventions included placing Resident #1 on 15-minute monitoring during exit seeking behaviors, and adding the resident to the "Adventure Club." However, according to the

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SSD in interview, the facility failed to alert staff to Resident #1's risk for elopement or train the staff on the interventions in place for staff to utilize to reduce the likelihood of the resident eloping from the facility. Further interview with the SSD revealed the facility's "Adventure Club" consisted of placing Resident #1's picture on a board in the facility's main dining room and front secretarial office, and could not specifically recall when/if the resident's picture was added to the board prior to 04/01/12.

A review of Resident #1's Minimum Data Set (MDS) assessment dated 03/14/12, revealed the facility assessed Resident #1 to be moderately cognitively impaired. Resident #1 was also assessed by the facility to have physical, verbal, and other behavioral symptoms such as pacing, rummaging, and being disruptive, which placed Resident #1 at significant risk for physical illness or injury and significantly interfered with the resident's care and participation in activities or social interaction with others.

A review of Resident Progress Notes dated 03/17/12, at 10:30 AM, for Resident #1 revealed the resident was "trying to get the patio door open," became agitated, and "said he was leaving the facility." However, Resident #1's record revealed no evidence that any interventions were implemented to address the resident's exit seeking behaviors. An interview with the Licensed Practical Nurse (LPN #1) on 04/26/12, at 11:00 AM, who was caring for Resident #1 on 03/17/12, and made the nursing entry, stated she was unaware Resident #1 had been identified by the facility to be an elopement risk on 02/28/12, and therefore did not know to initiate an

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increased level of supervision. LPN #1 stated, "I just thought (he/she) wanted to go out and smoke." LPN #1 stated to her knowledge Resident #1 had never worn a wander alert bracelet since being admitted to the facility and ambulated independently throughout the facility at will.

Interviews conducted on 04/25/12, at 12:03 PM with LPN #2, and at 3:45 PM with Certified Nursing Assistant (CNA) #1; on 04/26/12, at 11:20 AM with Registered Nurse (RN) #1; and on 04/27/12, at 11:58 AM with CNA #4, at 12:05 PM with CNA #3, at 12:10 PM with RN #2, at 12:15 PM with CNA #2, and at 12:20 PM with LPN #3, revealed none of the staff prior to 04/01/12, had been made aware that Resident #1 had been assessed to be at risk for elopement, and was unaware of any interventions to be utilized if the resident displayed exit seeking behaviors. Additionally, none of the staff interviewed had ever known Resident #1 to wear a wander alert bracelet, and stated Resident #1 had never been identified on the CNA assignment sheets to be at risk for eloping, or to utilize a wander alert bracelet.

An interview was conducted on 04/25/12, at 5:30 PM, with the Administrator. According to the Administrator, she was on medical leave during the time of Resident #1's elopement, and the incident was handled by the SSD. The Administrator also stated that behavioral concerns including residents at risk for elopement were addressed by the Social Services Department. The Administrator stated, however, that Resident #1's behavior was very erratic while in the facility and would change rapidly.

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*The facility implemented the following actions to correct the deficiency:

Resident #1 was returned to his/her unit and assessed to have sustained no injury. The resident was immediately placed on 1:1 monitoring, which continued until Resident #1 was transferred to the hospital on 04/11/12. Resident #1's attending physician and responsible party were notified of the resident's elopement from the facility.

On 04/01/12, the Charge Nurse reviewed and revised Resident #1's wander/elopement assessment to reflect the resident's risk for elopement. A wander alert bracelet was placed on the resident.

After Resident #1 returned to the unit on 04/01/12, the Weekend Supervisor conducted a resident head count and all other residents were accounted for.

On 04/01/12, the Director of Nursing (DON) reviewed all wander/elopement assessments for all residents previously identified at risk for elopement for accuracy. The assessments were deemed to be accurate.

On 04/02/12, the DON reviewed all residents' wander/elopement assessments for accuracy and all the assessments were deemed to be accurate.

On 04/01/12, the DON audited all exit doors and found them to be functioning appropriately.

On 04/02/12, the Director of Maintenance

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completed a Preventive Maintenance Check on the entire door system.

On 04/01/12, an audit was completed by the DON to ensure all wander guard transmitters on residents were intact and working, and no problems were identified. The transmitters will continue to be checked weekly by the Supply Clerk. No concerns have been identified.

On 04/01/12, the DON validated that all exit doors had signs stating "For the safety of our residents please be cautious when entering or exiting the building."

On 04/05/12, the Social Services Director (SSD) conducted an environmental audit of the internal and external environment to identify any accident hazards in the environment. No concerns were identified.

An audit of wander/elopement assessments for readmission for the past three months (February-April 2012) was conducted by the Case Manager (CM) and Minimum Data Set (MDS) Coordinator on 04/03/12. Four reassessments were taken to the Interdisciplinary Team meeting for review.

On 04/03/12, the Staff Development Coordinator (SDC) initiated education with all facility staff, to include all departments, on elopement/missing resident protocols. Education continued through 04/09/12. Staff was not allowed to work without having attended the in-service by 04/09/12.

On 04/02/12, the facility adopted the following procedure for dealing with residents who are

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F 323	Continued From page 22 newly identified as having wandering/exit seeking behaviors: The behavior will be immediately reported to the DON, SSD, and the Administrator. The resident will be immediately placed on 1:1 supervision until reviewed by the IDT in the morning stand-up meeting. At that time, the resident will be reassessed for risk of wandering/elopement. Further interventions will be determined based on the assessment findings. The behavior will be immediately placed on 24-hour shift documentation for a minimum of 72 hours related to exit seeking behaviors and/or attempts of elopement. Documentation will be placed on the 24-hour report each shift of resident behaviors or lack of behaviors. The behaviors will be immediately reported to the resident's physician and responsible party. The resident will be reassessed for risk of wandering/elopement risk using the wander/elopement assessment. A Behavior Assessment will be completed on the resident to determine the cause of the resident's new onset of distressing behavior and/or a recent attempt to elope by the Social Worker. The environment will be evaluated by the Maintenance Director.	F 323		

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The resident will be assessed to determine if there is a need for further assessment/evaluation from an outside resource.

The resident's care plan will be reviewed and revised by the IDT to include review of the Resident Progress Notes.

Medical records of all residents on increased supervision will be brought to the stand-up meeting every morning for a review of the Resident Progress Notes for the previous 24 hours and compare those to the current 24-hour report. On the weekend, the Weekend Supervisor will review the Resident Progress Notes of all residents on increased supervision.

The above procedure will be posted on each unit at the nurses' station and in the packets with new wander alert bracelet transmitters. The procedure will be reviewed in the monthly staff meeting for the next three months and will be included in orientation of new nursing staff.

On 04/06/12, the SSD mailed a letter to all families/responsible parties and visiting groups to remind everyone to exercise caution to ensure no resident leaves the building as someone is entering and/or exiting the facility.

The Admissions Director is educating all families of newly admitted residents on the door protocol and will document this education on the "Family/Resident Education Form." A letter educating families on the door protocol has been added to the admission packet as well. This started on 04/03/12, and is ongoing.

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An Elopement Audit was initiated on 04/02/12, and continues at least twice a week. Each resident identified at risk for elopement is audited to ensure that the wander/elopement assessment is up to date and accurate, the photo is on the assessment, the care plan is in place, the wander alert bracelet is in place on the resident, the resident's photo is in the book/binder, the resident's photo is on the adventure board, and the resident's care plan is being implemented. Care plan implementation will be validated through direct observation of the resident. The DON, SSD, or Weekend Supervisor is responsible to conduct the audit. Any concerns identified will be corrected at the time of the audit. The audit will be reviewed by the Interdisciplinary Team (IDT) the following day.

On 04/02/12, the SSD placed binders at each nursing station and at the front desk containing pictures, assessments, and care plans of all residents identified at risk for elopement. The SSD audits the binders weekly and makes revisions if necessary.

The Admitting/Charge Nurse conducts an assessment of all re-admissions for wandering/elopement risk on the wander/elopement assessment. The wander/elopement assessments are reviewed by the IDT or the Weekend Supervisor the day following a resident admission to ensure consistency and accuracy in the assessment. Quarterly reassessments are completed by the Charge Nurses and reviewed by the SSD and/or the Administrator for any changes. If there are changes from the previous assessment, the reassessment will be taken the following morning

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to the IDT meeting for review and/or revision by the IDT. Review by the IDT will consist of reviewing resident progress notes, 24-hour report, behavior monitoring logs, and any other pertinent information.

The Performance Improvement Committee (PIC) Administrator, DON, SDC, Activity Director (AD), Nutrition Services Manager (NSM), Director of Operations, Unit Manager, SSD, and Minimum Data Set Coordinator (MDSC) met on 04/03/12, and reviewed the investigative findings, audits, and action plan created in response to the elopement of 04/01/12. The Medical Director reviewed the action plan on 04/03/12.

All audits will be tracked and trended and reviewed at the monthly Performance Improvement Committee (members include, but are not limited to the Administrator, DON, SSD, SDC, Maintenance Director, Medical Records Director, Registered Dietitian (RD), Activity Director, Nursing Services Manager, Minimum Data Set Coordinator, and Medical Director) for three months and as needed thereafter.

**The surveyor validated the corrective action taken by the facility as follows:

A review of Resident #1's medical record revealed the facility had assessed the resident and found no injuries. Documentation revealed the resident was placed on 1:1 monitoring until transfer to the hospital on 04/11/12, and documentation was present of physician/responsible party notification. Interviews with direct staff throughout the investigation revealed Resident #1 remained on

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	185408	A. BUILDING _____ B. WING _____	C 04/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-LIBERTY	616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539

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1:1 until transferred from the facility.

Interview with LPN #1 on 04/26/12, at 11:00 AM, and review of the wander/elopement assessment for Resident #1 dated 04/01/12, revealed the form had been updated to reflect the resident's risk for elopement.

Interview with RN #1 on 04/26/12, at 11:20 AM, and facility documentation revealed she had completed a head count for the entire facility after Resident #1 was returned inside the building and identified no concerns.

Interview with the DON on 04/27/12, at 11:25 AM, and review of facility documentation confirmed the DON had performed the following actions: On 04/01/12, the DON reviewed all wander/elopement assessments for all residents previously identified at risk for elopement for accuracy. The assessments were deemed by the DON to be accurate. The DON also audited all exit doors and found them to be functioning appropriately, audited all wander guard transmitters on residents to confirm they were intact and working and no problems were identified, and validated that all exit doors had signs stating "For the safety of our residents please be cautious when entering or exiting the building." Additionally on 04/02/12, the DON confirmed and reviewed all resident wander/elopement assessments for accuracy and all the assessments were deemed to be accurate.

Interview with the Central Supply Clerk on 04/27/12, at 1:05 PM, confirmed they were responsible for continuing to check transmitters weekly.

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Interview with the Director of Maintenance on 04/27/12, at 1:00 PM, and review of a Preventive Maintenance Task Sheet dated 04/02/12, revealed on 04/02/12, the Director of Maintenance completed a Preventive Maintenance Check on the entire door system and identified no concerns.

Interview with the SSD on 04/27/12, at 11:15 AM, and review of an Environmental Audit dated 04/05/12, confirmed the SSD on 04/05/12, conducted an environmental audit of the internal and external environment to identify any accident hazards in the environment. No concerns were identified. Additionally, the SSD confirmed, and review of facility copies of letters sent to families revealed, on 04/06/12, the SSD mailed a letter to all families/responsible parties and visiting groups to remind everyone to exercise caution to ensure no resident leaves the building as someone is entering and/or exiting the facility.

Interview with the Case Manager (CM) and Minimum Data Set (MDS) Coordinator on 04/27/12, at 11:32 AM, and review of an audit dated 04/03/12, confirmed an audit of wander/elopement assessments for all readmissions in the past three months (February-April 2012) was conducted by the Case Manager and Minimum Data Set (MDS) Coordinator on 04/03/12.

Interview with the SDC on 04/27/12, at 11:50 AM, and review of an Elopement Class Sign in sheet confirmed on 04/03/12, the Staff Development Coordinator (SDC) initiated education with all facility staff, to include all departments, on

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elopement/missing resident protocols. Education continued through 04/09/12. Staff was not allowed to work without having attended the in-service by 04/09/12. Interviews conducted on 04/27/12, at 11:32 AM with the Case Manager and MDS Coordinator, at 11:58 AM with CNA #4, at 12:05 PM with CNA #3, at 12:10 PM with RN #2, at 12:15 PM with CNA #2, at 12:20 PM with LPN #3, at 1:00 PM with the Maintenance Director, and at 1:05 PM with the Central Supply Clerk revealed all the staff had attended the in-service, and was knowledgeable regarding the facility's elopement policies and procedures including the new procedure for dealing with residents who are newly identified as having wandering/exit seeking behaviors

Observations on 04/27/12, at 1:20 PM, confirmed the procedure for dealing with residents who are newly identified as having wandering/exit seeking behaviors was posted on each unit at the nurses' station and in the packets with new wander alert bracelet transmitters.

Interview with the Administrator on 04/27/12, at 11:53 AM, and review of documentation of newly admitted residents on 04/12/12, 04/19/12, 04/24/12, and 04/26/12, confirmed the Admissions Director had educated the families of the new residents on the door protocol and documented the education on the "Family/Resident Education Form." Review of a facility admission packet on 04/27/12, confirmed a letter educating the family regarding the door protocol was contained in the packet.

Review of wander/elopement assessment Audits dated 04/02/12, 04/03/12, 04/04/12, 04/05/12,

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F 323	Continued From page 29 04/06/12, 04/07/12, 04/08/12, 04/13/12, 04/16/12, 04/19/12, and 04/24/12, confirmed Elopement Audits were initiated on 04/02/12, and have continued at least twice a week. Observations on 04/27/12, at 1:18 PM, revealed "Adventure Club" binders were located at both nurses' stations and at the front desk. The binders contained resident pictures, assessments, and care plans of all residents identified at risk for elopement. A review of an audit of wander/elopement assessments conducted after readmission confirmed all readmissions from 04/02/12-04/25/12, had been reassessed the day after readmission to the facility. A review of Performance Improvement Committee (PIC) Minutes dated 04/03/12, confirmed the PIC met on 04/03/12, and reviewed the investigative findings, audits, and action plan created after the elopement of Resident #1 on 04/01/12.	F 323		